

**STATE OF MICHIGAN**  
**DEPARTMENT OF LICENSING & REGULATORY AFFAIRS**  
**OFFICE OF FINANCIAL AND INSURANCE REGULATION**  
**Before the Commissioner of Financial and Insurance Regulation**

**In the matter of**

**XXXXXX**

**Petitioner**

**v**

**File No. 121674-001**

**Humana Insurance Company**  
**Respondent**

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**Issued and entered**  
**this 8th day of November 2011**  
**by R. Kevin Clinton**  
**Commissioner**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On June 1, 2011, XXXXX, authorized representative of XXXXX (Petitioner), filed a request with the Commissioner of Financial and Insurance Regulation for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Commissioner immediately notified Humana Insurance Company (Humana) of the external review request and asked for the information it used to make its final adverse determination. The information was provided on June 2, 2011. On June 8, 2011, after a preliminary review of the information received, the Commissioner accepted the request for external review.

On July 27, 2011, the Petitioner's authorized representative filed another request for external review raising the same issues that were raised in the first request but for additional dates of service. Both requests are consolidated for review in this order.

The issues here can be decided by applying the terms and conditions of the Petitioner's health care coverage. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

## **II. FACTUAL BACKGROUND**

The Petitioner is covered under a small group health care plan that is underwritten by Humana. Her benefits are defined in a *Certificate of Coverage* (the certificate) issued by Humana. The coverage was effective on February 1, 2011.

The Petitioner received mental health services from XXXXX, PhD. Humana covered the services as a non-network benefit subject to the non-network deductible and the non-network coinsurance percentage.

The Petitioner appealed Humana's decision to process the claims as non-network benefits. At the conclusion of the internal grievance processes, the Petitioner received Humana's final adverse determinations dated May 12, 2011 and July 7, 2011, upholding its decisions. The Petitioner now asks the Commissioner to review those determinations.

## **III. ISSUE**

Did Humana correctly process the mental health services as non-network benefits?

## **IV. ANALYSIS**

### Petitioner's Argument

The Petitioner believes Humana improperly processed her claims for mental health services as non-network benefits. In a letter dated May 25, 2011, that accompanied Petitioner's first request for external review, her authorized representative wrote:

The primary issue is that the claims were processed as non-network provider claims and allocated to the higher out-of-network deductible when the provider, XXXXX, Ph.D., was a network provider in the Cofinity network, the network represented to us as the network applicable to our coverage and which we, the beneficiary members and the employer . . . based our decision to purchase the coverage from Humana.

I am both the affected beneficiary or member and the Principal of the employer and policy insured . . . and I was the individual to whom the representations were made and the decision maker for the insured firm with respect to purchasing the policy.

Humana denied the appeal and asserts that the provider, XXXXX, Ph.D., is not a network provider based on a secret undisclosed smaller network, called XXXXX, which they claim applies to Behavioral Treatment Providers, only. This network was not disclosed to us in the policy or in any communications we

received prior to the placement of coverage. . . . It is undisputed that Dr. XXXXX is in the Cofinity Network. . . .

[The Petitioner] established a long-term trusted treatment relationship with the provider, a licensed psychologist and it would be detrimental to her treatment and mental health to be required to change therapist in mid-stream. Based on the representations of Humana and its agent, National Benefits Plan, we checked to see if all our providers, including XXXXX were in the Network prior to agreeing to the placement of coverage. She was and is in the Cofinity Network. . . . We made it clear that having our providers in the Network was very important to us. . . .

The representations were that Cofinity Network Providers were covered by our plan as Network Providers. . . . The agent agrees with us and disagrees with Humana. . . . Our provider also told us she was an approved Humana Network provider.

The policy does not disclose that there is a different network for Behavioral Care Treatment. There is no mention of the XXXXX Network that Humana claims applies to our policy.

\* \* \*

We respectfully request that Humana's decision be reversed and that it be determined that Cofinity providers are Network providers for our policy and that the above claims and future claims of provider XXXXX be treated as Network Provider charges.

### Respondent's Argument

There is no dispute that mental health services are covered under the certificate. The dispute in this case is whether the mental health services the Petitioner received should be covered as network or non-network benefits. In the section entitled "Understanding Your Coverage," at page 7, the certificate states:

#### **Your choice of providers affects your benefits**

In most cases, if *you* receive services from a *network provider*, we will pay a higher percentage of benefits and *you* will incur lower out-of-pocket costs. *You* are responsible for any applicable *deductible*, *coinsurance* and/or *copayment*.

If *you* receive services from a *non-network provider*, we will pay benefits at a lower percentage and *you* will pay a larger share of the costs. Since *non-network providers* have not agreed to accept discounted or negotiated fees, they may bill *you* for charges in excess of the *maximum allowable fee*. *You* are responsible for charges in excess of the *maximum allowable fee* in addition to any applicable *deductible*, *coinsurance* and/or *copayment*. Any amount *you* pay to the provider in excess of *your coinsurance* or *copayment* will not apply to *your out-of-pocket*

*limit or deductible.*

Humana states that non-network services are subject to a \$7,500.00 individual deductible and when that deductible has been met, Humana pays 70% of its allowed amount for covered services.<sup>1</sup>

In its May 12, 2011, final adverse determination, Humana explained its decision to cover the mental health services as non-network benefits:

Claim[s] . . . were processed at the non network provider level of benefits. XXXXX is a non-participating provider with the network associated with your plan. The benefit for Behavioral Health services with a non network provider is 70 percent benefit payable after non network provider deductible. The claims applied the allowed amounts toward the non network provider deductible.

Humana gave a similar rationale in its July 7, 2011, final adverse determination.

Humana states that the Petitioner's providers are in the ChoiceCare network, not the Cofinity network. Since Dr. XXXXX does not participate in the ChoiceCare network, Humana argues her services are non-network benefits.

#### Commissioner's Review

The Petitioner's authorized representative indicates that Humana and its representatives told him that Cofinity would be the provider network for the Petitioner's health plan. He states that he checked to make sure that Dr. XXXXX was in the Cofinity network and, finding that she was, entered into coverage with Humana, presumably acting in reliance on the alleged misinformation. Humana states that the ChoiceCare network, not Cofinity, is the Petitioner's network and that Dr. XXXXX is not a provider in that network.

A review under the Patient's Right to Independent Review Act (PRIRA) cannot resolve this kind of dispute. The PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements. Moreover, the Commissioner does not have the authority under PRIRA to base a decision on doctrines such as reliance or estoppel. Under PRIRA, the Commissioner's role is limited to determining whether Humana correctly administered health care benefits under the terms and conditions of the applicable insurance certificate and relevant state law.

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<sup>1</sup> The individual deductible for network services is \$2,500.00.

Humana states that ChoiceCare is the provider network for the Petitioner's plan. The Petitioner does not dispute that; her authorized representative only argues that he was given misinformation about the correct provider network from Humana or Humana's agent. The Petitioner also does not argue that Dr. XXXXX is in the ChoiceCare network, only that she is in the Cofinity network. It is therefore undisputed that Dr. XXXXX is a non-network provider under the Petitioner's plan. Since the certificate is clear that benefits are paid based on the network status of the provider, the Commissioner concludes and finds that Humana correctly processed the Petitioner's mental health claims as non-network benefits subject to the non-network deductible and coinsurance.

Lastly, the Petitioner argues that Humana has impermissibly limited outpatient mental health visits to 15 per calendar year in violation of the federal Patient Protection and Affordable Care Act (PPACA). However, the Petitioner points to no statute or rule to support that contention and the Commissioner declines to decide the issue at this time because it is not clear in the record that the Petitioner had reached the 15 visit limit or that the issue of visit limitations was addressed during Humana's internal grievance process. However, the Commissioner observes that while PPACA requires health plans to include mental health services as an "essential health benefit," current law does not require small group plans (fewer than 50) to comply with the federal Mental Health Parity and Addiction Equity Act's requirement that mental health visit limitations be no more restrictive than those for other covered medical or surgical benefits.

## **V. ORDER**

The Commissioner upholds Humana Insurance Company's adverse determinations of May 12, 2011 and July 7, 2011. Humana is not required to cover the Petitioner's mental health services from XXXXX, PhD, as network benefits.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton  
Commissioner